

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012181	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/02/2011
NAME OF PROVIDER OR SUPPLIER RITTENHOUSE SENIOR LIVING OF VALPARAISO		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 VALE PARK ROAD VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for Investigation of Complaint IN00086753.</p> <p>Complaint IN00086753 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: March 2, 2011</p> <p>Facility Number: 012181 Provider Number: 012181 AIM Number: N/A</p> <p>Surveyor: Mary Anne Cilella, RN.</p> <p>Census Bed Type: Other: 79 Total: 79</p> <p>Census Payor Type: Other: 79 Total: 79</p> <p>Sample: 3</p> <p>Rittenhouse Senior Living of Valparaiso was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00086753.</p> <p>Quality review 3/03/11 by Suzanne Williams, RN</p>	R 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

K0ZU11

If continuation sheet 1 of 1